Community Specialist Palliative Care Referral Form

St Catherine's Hospice, Crawley

Tel: 01293 447333

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Email: stcatherineshospice.admin@nhs.net

ST CATHERINE'S HOSPICE

Do you need advice/assessment within two working days? **Yes ☐** **No ☐**
If immediate assistance is required please phone for advice.

The specialist Palliative Care Team offer different levels of support: telephone advice; one off assessments; admission to a hospice unit and on-going management. If you are not sure of the support you require, please telephone the Palliative Team for guidance.

The principles and practices of palliative care are not the exclusive concern of specialist palliative care services and the team works collaboratively with GPs, District Nurses and other health & social care professionals involved in the care of patients to ensure needs are met. The Primary Healthcare Team will remain the primary point of contact for the patient and they are often able to meet the needs of many patients at the end of life.

Please send copies of any relevant recent correspondence with this form e.g. Consultant clinic letters and GP patient summary. NB. Insufficient information may delay patient assessment.

FAX MESSAGE

From:

To:

Fax No:

Date:

No of pages (including cover sheet):

Additional information:

March 2016

ESSENTIAL PATIENT DETAILS

Referral Date:

Surname: _____ Male ☐ Female ☐ DOB: _____

First Name: _____ Known as: _____ Age: _____

Address: _____

Town: _____

County: _____

Postcode: _____

Telephone: _____

Email: _____

NHS No. _____

Hospital No. _____

Ethnic status

White British	☐	Bangladeshi	☐	Other black	☐
Mixed white/ black Caribbean	☐	White Irish	☐	Other white	☐
		Mixed white/black African	☐	Pakistani	☐
Mixed white Asian	☐	Other mixed	☐	Other Asian	☐
Indian	☐	Black African	☐	Black Caribbean	☐
Chinese	☐	Other	☐	Not stated	☐

Marital status: Married ☐ Single ☐ Civil partnership ☐ Divorced ☐ Widowed ☐ Co-habiting ☐ Separated ☐

Next of Kin/Patient representatives

Surname: _____

First Name: _____

Address: _____

_____

Postcode: _____

Telephone: _____

Email: _____

Relationship to patient: _____

Main Carer (if different from above)

Surname: _____

First Name: _____

Address: _____

_____

Postcode: _____

Telephone: _____

Email: _____

Relationship to patient: _____

General Practitioner

Name: _____

Surgery: _____

Postcode: _____

Telephone: _____

Fax: _____

Secure email: _____

GP aware of referral: Yes ☐ No ☐ **If "No" please inform GP**

Community Nursing Services

Name: _____

Based at: _____

Telephone: _____

Fax: _____

Hub email: _____

Continuing Care funding in place Yes ☐ No ☐

Any communication difficulties:

Key reason for referral	**Service Requested**	**The patient is currently**
Pain/symptom management ……☐	Assessment in home……..☐	At home……☐
Emotional/psychological support…….☐	Day Hospice care……...☐	In hospital……..☐
Social/financial……☐	Admission to Hospice……☐	Other care setting ……...☐
Carer support ……☐	Assessment Community Hospital……☐	(please state where)
Other reason ……..☐		

Hospital/community professional Involved with patient's care:	**If in hospital, please complete the following:**	
Name:	Ward:	Date of discharge:
Based at:	Direct Ward Ext:	Is Hospital Palliative Care Team involved? Yes ☐ No ☐
Telephone:	Direct telephone:	If "No" please consider review by the Hospital Palliative Care Team
Fax:	Consultant:	

MRSA/C. difficile/other status: Positive ☐ Negative ☐ Not known ☐ Specify:

Diagnosis and relevant clinical history

Does the patient have capacity Yes ☐ No ☐

Has the patient consented to this referral Yes ☐ No ☐

CLINICAL INFORMATION

Referral Date:

Patient Name:	**Date of Birth:**

Patient's main problems/issues (Please add details explaining reason for referral)

1. _____
2. _____
3. _____
4. _____
5. _____

Additional relevant information (psychosocial/spiritual)

Past medical & psychiatric history (please attach GP summary and details of current medication)

Patient mobility:

Drug and non-drug sensitivities/allergies Yes ☐ No ☐ Specify:

Phase of illness:	**Stable** Yes ☐ No ☐	**Unstable** Yes ☐ No ☐	**Deteriorating** Yes ☐ No	**Dying** Yes ☐ No ☐

Patient on the GSF register	Yes ☐ No ☐	Preferred place of care:	
DNACPR in place (please send a copy)	Yes ☐ No ☐	Preferred place of death:	
Last days of life care plan started	Yes ☐ No ☐		

Please expand on any discussions above:

Has patient been fitted with:

Implantable Cardiac Defibrillator	Yes ☐ No ☐	ICD deactivated	Yes ☐ No ☐
Has patient been told diagnosis	Yes ☐ No ☐	Is the carer aware of patient's diagnosis	Yes ☐ No ☐
Does the patient discuss the illness freely	Yes ☐ No ☐	Does the carer discuss the illness freely	Yes ☐ No ☐

Please ensure the patient is aware information will be held on computer according to the Data Protection Act and will be shared with external healthcare professionals on a need to know basis

Referrer's signature _____ Name (please print): _____

Job title: _____ Dated: _____

Contact tel: _____

Surgery or Hospital: _____ Bleep No: _____

_____ Fax no: _____